

**COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**PUBLIC NOTICE REGARDING MEDICAID REIMBURSEMENT CHANGES**

The Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS), in accordance with 42 CFR 447.205, hereby provides public notice of its intent to establish new reimbursement for various Medicaid Program services (including many new services) effective January 1, 2014. The respective new reimbursements are described under the corresponding headings below.

**Physical Therapy Services**

In addition to the provider types that DMS currently reimburses for physical therapy services, DMS is expanding the provider base to pay for physical therapy services provided by physical therapists who enroll with the Medicaid Program as independent providers as well as to pay for physical therapy services provided by physical therapy assistants who work for an independently enrolled physical therapist provided that the physical therapist is the billing provider for the services.

DMS's reimbursement for physical therapy services provided by an independently enrolled physical therapist will be 63.75% of the rate on the current Kentucky-specific Medicare Physicians' Fee Schedule for the service.

DMS's reimbursement for physical therapy services provided by a physical therapy assistant working for an independently enrolled physical therapist will be 37.5% of the rate on the current Kentucky-specific Medicare Physicians' Fee Schedule for the service.

**Occupational Therapy Services**

In addition to the provider types that DMS currently reimburses for occupational therapy services, DMS is expanding the provider base to pay for occupational therapy services provided by occupational therapists who enroll with the Medicaid Program as independent providers as well as to pay for occupational therapy services provided by occupational therapy assistants who work for an independently enrolled occupational therapist provided that the occupational therapist is the billing provider for the services.

DMS's reimbursement for an occupational therapy service provided by an independently enrolled occupational therapist will be 63.75% of the rate on the current Kentucky-specific Medicare Physicians' Fee Schedule for the service.

DMS's reimbursement for an occupational therapy service provided by an occupational therapy assistant working for an independently enrolled occupational therapist will be 37.5% of the rate on the current Kentucky-specific Medicare Physicians' Fee Schedule for the service.

**Speech Pathology Services**

In addition to the provider types that DMS currently reimburses for speech pathology services, DMS is expanding the provider base to pay for speech pathology services provided by speech-language pathologists who enroll with the Medicaid Program as independent providers.

DMS's reimbursement for a speech pathology service provided by an independently enrolled speech-language pathologist will be 63.75% of the rate on the current Kentucky-specific Medicare Physicians' Fee Schedule for the service.

### **Mental Health and Substance Use Disorder Services Provided by Independent/Individual Providers**

DMS is expanding the scope of mental health and/or substance use disorder services it covers. Additionally, DMS is expanding the provider types authorized to provide mental health and substance use disorder services to include certain providers (listed below) that can enroll with the Medicaid program as independent providers (rather than being employed by an agency.) DMS is also expanding authorized practitioners to include the practitioners (listed below) who can provide services while working for an independently enrolled provider as long as the independently enrolled provider is the billing provider for the services.

DMS's reimbursement for mental health and substance use disorder services provided by independently enrolled providers (or by a practitioner working for an independently enrolled provider) will be as follows:

(1) One (1) unit will be fifteen (15) minutes in length for each service or the unit identified in the respective Current Procedural Terminology (CPT) code.

(2) The rate per unit for a screening will be:

(a) 75.0% of the rate on the current Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a physician or psychiatrist;

(b) 63.75% of the rate on the current Kentucky-specific Medicare Physician Fee Schedule for the service if provided by an advanced practice registered nurse (APRN) or licensed psychologist (LP);

(c) 60.0% of the rate on the current Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a licensed professional clinical counselor (LPCC), licensed clinical social worker (LCSW), licensed psychological practitioner (LPP), or licensed marriage and family therapist (LMFT); or

(d) 52.5% of the rate on the current Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a marriage and family therapy associate (MFTA) working under the supervision of an LMFT if the LMFT is the billing provider for the service; licensed professional clinical counselor associate (LPCA) working under the supervision of an LPCC if the LPCC is the billing provider for the service; licensed psychological associate (LPA) working under the supervision of an LP if the LP is the billing provider for the service; certified social worker (CSW) working under the supervision of an LCSW if the LCSW is the billing provider for the service; or physician assistant (PA) working for a physician if the physician is the billing provider for the service.

(3) The rates per unit for the following services will be the same as stated above for a screening:

(a) An assessment;

(b) Screening, brief intervention, and referral to treatment;

(c) Crisis intervention;

(d) Service planning;

(e) Individual outpatient therapy;

(f) Family outpatient therapy;

(g) Group outpatient therapy; and

(h) Collateral outpatient therapy.

- (4) The rate per unit for psychological testing will be:
- (a) 63.75% of the rate on the current Kentucky-specific Medicare Physician Fee Schedule for the service if provided by an LP; or
  - (b) 60.0% of the rate on the current Kentucky-specific Medicare Physician Fee Schedule for the service if provided by an LPP; or
  - (c) 52.5% of the rate on the current Kentucky-specific Medicare Physician Fee Schedule for the service if provided by an LPA working under the supervision of an LP if the LP is the billing provider for the service.
- (5) The rate per unit for medication assisted treatment will be:
- (a) 75% of the rate on the current Kentucky-specific Medicare Physician Fee Schedule for the service if provided by a physician or psychiatrist; and
  - (b) 63.75% of the rate on the current Kentucky-specific Medicare Physician Fee Schedule for the service if provided by an APRN.
- (6) DMS will not reimburse for a service billed by or on behalf of an entity or individual who is not a billing provider.

**Expanded Scope of Services and Corresponding Reimbursement for Entities including: Federally-qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Primary Care Centers (PCCs), Local Health Departments (LHDs), Community Mental Health Centers (CMHCs), and other qualified entities**

In addition to authorizing the aforementioned independent mental health/substance use disorder service providers listed above to provide the services listed above, DMS is expanding the scope of services that DMS will cover when provided by appropriate entities, including a federally-qualified health center (FQHC), a rural health clinic (RHC), a primary care center (PCC), a local health department (LHD), a community mental health center (CMHC), or another qualified entity to also encompass the same mental health/substance use disorder services listed above. In addition to those services, DMS is also authorizing entities, when appropriate in their scope of practice and state and federal regulation to provide the following:

- Mobile crisis services
- Assertive community treatment
- Peer support
- Comprehensive community support services
- Medication assisted treatment
- Intensive outpatient program services
- Residential crisis stabilization
- Day treatment
- Partial hospitalization
- Residential services for substance use disorders
- Therapeutic rehabilitation program

DMS's reimbursement methodology for the new services authorized to be provided by an FQHC and RHC will be the same methodology employed by DMS for services currently covered in those settings.

DMS's reimbursement methodology for the new services authorized to be covered by a PCC and LHD will be the same methodology employed by DMS for services currently covered in those settings, except for intensive outpatient program services.

DMS's reimbursement methodology for the new services authorized to be provided by CMHC will be the same methodology employed by DMS for services currently covered in a CMHC.

DMS's reimbursement methodology for the following services when provided by a qualified entity, not listed above, will be:

- Residential services for substance use disorders: \$230 per diem
- Day treatment: Based on the Medicare fee schedule methodology described above
- Partial hospitalization: \$194.10 per diem
- Intensive outpatient program: \$58.26 per diem
- Assertive Community Treatment (ACT):
  - \$750 per month for four person team
  - \$1,000 per month for 10 person team

### **Expanded Scope of Services and Corresponding Reimbursement for Psychiatric Hospitals**

DMS is expanding the scope of services covered in a psychiatric hospital to include partial hospitalization services. DMS will reimburse for partial hospitalization services in a psychiatric hospital at a per diem rate of \$194.10.

### **Private Duty Nursing Services**

DMS is expanding its coverage of Medicaid benefits to include private duty nursing services provided by a private duty nursing agency or a home health agency that is licensed to provide private duty nursing services. DMS will reimburse for private duty nursing services at a rate of nine dollars per fifteen minutes. DMS will not reimburse for more than ninety-six units per recipient per twenty-four hour period or 8,000 units per twelve-consecutive month period per recipient.

### **Reasons**

DMS is taking the actions regarding independent therapy providers and independent mental health and substance use disorder service providers as it is expanding its base of enrolled providers to help ensure that Medicaid recipients will have access to Medicaid covered services. DMS is anticipating a substantial increase of individuals receiving Medicaid benefits as a result of adding the "Medicaid expansion group" to its array of Medicaid eligible individuals and adding the federally-mandated new eligibility group comprised of former foster care individuals between the ages of nineteen and twenty-six who aged out of foster care while receiving Medicaid. Additionally, DMS anticipates that a significant number of individuals who would have qualified under the "old" Medicaid eligibility rules (rules in place prior to the modified adjusted gross income or "MAGI" rules) but did not apply, will apply as a result of the publicity associated with the Medicaid expansion and with the health insurance/benefit exchange (also known as "KYNECT") and gain eligibility.

DMS is adding private duty nursing services to its array of covered services as a result of Affordable Care Act requirements.

DMS is expanding its coverage of substance use disorder services beyond its current scope (which is coverage for pregnant women and children) as a result of an Affordable Care Act mandate to cover substance use disorder services for all.

**Impact on Expenditures**

DMS is unable to project an expenditure increase associated with the actions described in this notice due to all of the variables involved in these actions. DMS cannot predict how many of the above listed providers will choose to enroll in the Medicaid program, nor how quickly they will enroll, nor how quickly they will begin serving Medicaid recipients. Additionally, DMS is unable to predict how many Medicaid recipients will require services from the above-listed providers.

**How to Submit Comments**

A copy of this notice is available for public review at the Department for Medicaid Services at the address listed below. Comments or inquiries may be submitted in writing within thirty (30) days to the email address of [MedicaidRates@ky.gov](mailto:MedicaidRates@ky.gov)

Written comments may also be submitted to the following postal mail address:

Department for Medicaid Services  
Commissioners Office  
ATTN: Medicaid Reimbursement Comments  
275 E. Main Street, 6W-A  
Frankfort, Kentucky 40621